HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

I. GENERAL PATIENT INFORMATION

Date: ____/____/____

Name: _____ E-mail Address: _____

Address: _____ City, State, Zip: _____

Home Phone: (____)_____ Work Phone: (____) _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____

Gender: ☐ M ☐ F Height: _____ Weight: _____ lbs.

Occupation: _____

Employer: _____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1 _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

How do these conditions impair your daily activities? _____

_____

II. PATIENT MEDICAL HISTORY

How was your childhood health? _____

Hospitalization(s): _____

Recent tests: (please indicate the test results and date below)

☐ Physical ☐ Cholesterol ☐ Blood (which?) Other: _____

Test Results and Date _____

Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding tendency
☐ Measles	☐ Chicken pox	☐ Nervous disorder	☐ Mononucleosis
☐ Meningitis	☐ HIV	☐ Polio	☐ Multiple Sclerosis
☐ Epilepsy	☐ High Fever	☐ Hepatitis	☐ High blood pressure
☐ Paralysis	☐ Cancer	☐ Migraines	
☐ Other Lung illnesses	☐ Other Liver illnesses	☐ Other Heart illnesses	☐ Other Kidney illnesses

Other: _____

Immunizations: _____

Surgeries: _____

III. FAMILY MEDICAL HISTORY

Please indicate any significant illnesses your or a blood relative (Grandparent, parent or sibling) have had:

	You	Your Relative	Approx. Date		You	Your Relative	Approx. Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____

IV. STD

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ AIDS ☐ HPV ☐ Chlamydia ☐ Herpes Date _____

V. MEDICATIONS

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

VI. COFFEE/ALCOHOL/TOBACCO

VI. Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda pop	☐	☐	_____

VII. HOW DO YOU FEEL ABOUT THE FOLLOWING AREAS OF YOUR LIFE?

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your comments:
Significant Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

IX. DIAGNOSTIC QUESTIONS

1. TEMPERATURE

Body	___ Hot	___ Cold	___ Neutral
Hands	___ Hot	___ Cold	___ Neutral
Feet	___ Hot	___ Cold	___ Neutral
Sweat	___ Hands	___ Feet	___ Spontaneous
	___ Chest	___ Flush	___ Rarely

2. BOWEL MOVEMENTS

___ Diarrhea	___ Urgency	___ x day
___ Loose	___ Incomplete	___ x week
___ Formed	___ Blood	___ Mucous
___ Constipation	___ Undigested food	___ Black tarry

3. URINATION

___ Colorless/clear	___ Urgency	___ Cloudy
___ Straw/normal	___ Frequent	___ Burning/pain
___ Dark/concentrated	___ Scanty	___ Strong Odor
___ Reddish	___ Profuse	___ Discharge

4. APPETITE/THIRST

___ Eat breakfast	___ Drink water
___ No appetite	___ No thirst
___ Excessive appetite	___ Excessive thirst
___ Eat after 8:00 p.m.	___ Drink after 8:00 p.m.

5. SLEEP

___ Trouble falling asleep	___ Wake earlier than normal
___ Restless Sleep	___ Wake earlier than normal
___ Vivid dreams/nightmares	___ Wake in middle of night

6. DIET Servings a day:

Red Meat	_____
Chicken/Fish/Eggs	_____
Dairy/Milk/Cheese	_____
Fruit	_____
Vegetables	_____
Whole Grains	_____
Nuts & Seeds	_____
Rice, Pasta, Bread	_____
Sweets	_____

7. EXERCISE

___ Cardio ___ Weights
___ Yoga ___ Walking
___ Tai-chi ___ Other _____
_____ x a week Hours per week _____

X. FOR WOMEN

Age of 1st period (menarche) _____
Age of last period (menopause) _____
Number of days between periods _____
Number of days of flow _____
Color of Flow _____
Clots? ☐ Yes ☐ No Color _____

Are you pregnant? ☐ Yes ☐ No # of pregnancies _____
# of Live births_____ # of Abortions_____ # of Miscarriages_____
Date of last Gynecologic exam _____ Pap Smear _____
Mammogram _____ Bone Density Scan_____
Results _____
_____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other _____

Location of Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs Other _____

Nature of Pain: (Please indicate before, during or after menses)

Cramping _____	Stabbing _____
Burning _____	Aching _____
Dull _____	Bloating _____
Consistent _____	Intermittent_____
Bearing down sensation _____	

Other Symptoms related to menses:

☐ Discharge	☐ Vaginal dryness	☐ Headache
☐ Nausea	☐ Constipation	☐ Diarrhea
☐ Swollen breasts	☐ Mood swings	☐ Ravenous appetite
☐ Poor appetite	☐ Hot flashes	☐ Night sweats
☐ Increased libido	☐ Decreased libido	☐ Insomnia

XI. FOR MEN

Date of last prostate check up_____ PSA results _____ Manual prostate exam results _____
Lab results _____

☐ Prostate problems	☐ Delayed stream	☐ Dribbling	☐ Incontinence	☐ Retention of urine
☐ Rectal dysfunction	☐ Increased libido	☐ Decreased libido	☐ Premature ejaculation	☐ Impotence
☐ Back pain	☐ Groin pain	☐ Testicular pain	Other _____	

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

	(Date)
PATIENT SIGNATURE **X**	07/06/16
(Or Patient Representative)	(Indicate relationship if signing for patient)
OFFICE SIGNATURE **X**	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

PATIENT SIGNATURE X (Date) 07/06/16

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE